Telemedicine Clinical Advisory Group (TCAG)
August 4, 2010
Meeting Notes

Attended in person
Robert Bass-MIEMSS, TCAG Chair, Barney Stern, U of Maryland, Anna Aycock-MIEMSS, Rich Colgan-UMB, Grace Zaczek-DHMH, Neal Reynolds –STC/MEDCHI, Jennifer Witten-American Heart & Stroke Association, Sarah Orth-Maryland Health Care Commission, Michelle Clark-Maryland Rural Health Association, Eric Aldrich-JHHS/HCGH, Peggy Naleppa-PRMC, David Finney-CRISP Consultant, Laura Pimentel-ACEP
Attended via teleconference
Jo Wilson-Western Maryland Health System, Salliann Alborn-Community Health Integrated Partnerships, Mimi Novello-Medstar Health, Frank Genova-Kaiser, Jennifer Fahey-U of M SOM, Stephen Michaels-St. Mary's Hospital/Medstar, Michael Franklin–Atlantic General Hospital, Nicole Stallings-DHMH, Amjad Riar, Governor's Commission on Asian Pacific American Affairs, Frank Genova-Kaiser, E. F. Magee-MIEMSS, Pat Gainer-MIEMSS, Eric Stoddard–U of M CHHS, Marek Mirski – Johns Hopkins. Lori Brewster – Wicomico County Health Department, Michelle Hardy-Wicomico County Health Department, Dan Winn-CareFirst, Karen Rezabek-MHCC

Welcome & Introductions
Dr. Bass welcomed everyone and introductions were made.

TCAG Discussion Notes from 7/21/11
Meeting notes were approved as written for posting to the web site.

Use Case Discussion
A copy of the Maryland Telemedicine/Telehealth final report was disseminated. Dr. Bass asked if there were any additional programs, beyond what is listed in the survey that are being utilized in Maryland that should be included; if so, please email program names to Barbara Goff bgoff@miemss.org Ms. Naleppa noted that under Maryland eCare, PRMC currently has 32 of its 52 beds under eCare. Ms. Naleppa also stated that she sits on the CRISP Financial Committee. Dr. Reynolds noted that the Bon Secours/ Shock Trauma TeleICU program was not on the list and will send the program information.

Mr. Finney asked how the group is defining "Telemedicine". Ms. Naleppa stated that hospitals use the Joint Commissions definition of Telemedicine. Dr. Reynolds noted that the American Telemedicine Association also has a description on their website. Mr. Magee added that DHMH has a regulation that defines Telemedicine:

10.32.05 Telemedicine .02 Definitions

B.(6) "Telemedicine" means the practice of medicine from a distance, in which intervention and treatment decisions and recommendations are based on clinical data, documents, and information transmitted through telecommunications systems.

Dr. Bass advised that he would look for the Joint Commissions definition to crosswalk with the DHMH definition.

Chesapeake Regional Information System for our Patients (CRISP)
Dr. Bass introduced David Finney, CRISP Consultant. Mr. Finney gave an overview of CRISP via power point (addendum) presentation which will be posted to the web site http://www.dhmh.state.md.us/mhqcc/telemedicine.html

CRISP is a non-profit designated by MHCC as Maryland's statewide health information exchange (HIE) funded by hospital rates and federal stimulus monies. The Regional Extension Center (REC) is funded by the Office of the National Coordinator of Health IT (ONC) through the stimulus bill and offers technical implementation, and educational assistance to facilitate providers' adoption and meaningful use of electronic medical records (EMRs).

Mr. Finney gave an overview of the governance structure of CRISP.

Mr. Finney stated that currently CRISP is a structured data exchange and registry for lab reports, radiology, prescriptions, hospitals, long term care facilities and private practices. Very few images are exchanged. Depending upon the level of integration at each receiving facility, lab reports can be text reports or integrated into the EMR. CRISP also has a web based portal that credentialed doctors can use to query for patient records; which flows outside of the EMR. Lab reports can also be pushed from one provider site to another as long as the physician is on the network regardless of the lab being utilized; currently Lab Corp, Quest and some of the hospital labs are connected. Clinicians can also subscribe to individual patients; if there are new documents attached to a certain identity alerts can be sent to the physician. CRISP is a federated model where the information can sit on the edge servers at each hospital/facility. CRISP has contracted with AXOLOTL to provide the infrastructure and IBM Initiate for master patient data that will contain demographic data for indexing.

Dr. Bass stated that most of Maryland EMS should be on an electronic patient care reporting system within the next twelve months and perhaps an edge server could be created so that the patient record could also include the first medical encounter with the EMS provider.

Mr. Finney stated that the UMMS hospitals are currently testing the system and should be live within the next month or two. The goal is to have every hospital in Maryland exchanging patient demographics by the end of 2011.

Mr. Finney stated that there is a comprehensive participation agreement signed by participating hospitals noting that HPPA applies the same way as in the paper world and is auditable. CRISP is an "opt out" model; when a hospital goes live it modifies its notice of privacy practices to include language of participation in HIE. Credentialing is the participating organization's responsibility when allowing personnel access to patient records through CRISP.

Dr. Bass asked if Public Health will be connected. Mr. Finney stated that CRISP is weighing the value of new use cases including Public Health. The CRISP focus is on hospital connectivity. Dr. Bass stated that Public Health would be a worthy addition for syndromic surveillance, reportable lab values and outcomes.

Mr. Finney stated that HL7 is the standard for messages being transferred. Dr. Reynolds asked if CRISP will incorporate radiographic images and noted that a centrally located repository would

assist with standardization. Mr. Finney advised that CRISP is not considering at this time by could eventually. Dr. Stern added that this is an area where the TCAG and CRISP could interact effectively in terms of shared goals with regard to the master patient index and accessing these data points electively and emergently using a common language and through this process could leverage the TCAG initiative and CRISP's long term goal. Dr. Aldrich added that strategically the TCAG's time frame is more immediate than CRISP's in terms of transmitting images; as the group thinks about its clinical recommendations having the image capabilities as soon as possible will be best. Dr. Stern stated there is a de facto format for transmitting images but it is not a regulated technology. There needs to be communicability and transmissibility between diverse imaging platforms. Mr. Finney noted that it can take huge bandwidth requirements for moving diagnostic images and that has been one of the chief barriers. This would be something for the technology group consider.
After a discussion on how best to approach the ability to have a common language electronic imaging it was decided that Dr. Bass would discuss with David Sharp, Chair of the Telemedicine Technology Solutions Group, on how CRISP could assist with a technological linking process and, if possible, the time frame for implementation.

Mr. Finney advised that CRISP web portal that ambulatory and some hospital providers are using is not a certified VHR system and most likely never will be. A provider that is on paper and using the CRISP portal to query for data on the network will not be a path for meaningful use. Ms. Naleppa stated if it remains a data exchange only it could be an issue with what the TCAG is trying to accomplish from the broadband perspective.

Dr. Stern noted as telemedicine moves forward and assuming the telemedicine sessions are documented in some hard copy format we need to keep in mind that within the telemedicine environment the documentation that is created will need to link into the respective electronic medical record and then link into CRISP. As a standardization type of process we need to ensure continuity and perhaps later explore the essential elements of documentation of the telemedicine interaction and then customize for the various unique scenarios. Dr. Aldrich added that it is not just how much but how little information is needed. Dr. Bass said it is similar to a radiology report; you have the report that summarizes and then the image. The provider should document the encounter in the EHR format that will then go into the exchange so that you will have access to it no matter what hospital needs to access.

Dr. Riar stated that CRISP currently provides training and education to physicians adopting an EHR at no cost and asked if CRISP would provide training on telemedicine. Mr. Finney stated that the Regional Extension Center Program is mainly focused on getting primary care providers to meaningful use so they can get their EHR incentive payments from Medicare/Medicaid. This may be worth discussion if the was enough a market for that type of service.

Dr. Reynolds stated that radiology is part of acute telemedicine. We need to be more generic and discuss imaging to include i.e. EKG and ultrasounds; are we recommending that CRISP make this a priority. A decision will need to made regarding what is practical, realistic and the legal precedent for documentation and if a legal precedent be set by legislation. A discussion ensued regarding documentation that should be included in an electronic record.

- If you record a telemedicine session, do you need to store the recording and for how long
- How and where it would be stored

Dr. Bass stated that teleradiology is part of telemedicine. Dr. Reynolds stated that teleradiology is the interaction of the patient and the data needed to make a clinical decision. Dr. Pimentel added that includes the transmission and reading of the data back to the treating physician.

Mr. Finney showed the map of the current and future CRISP connected hospitals, reviewed the National EHR adoption trends and goals and gave an overview of the goals of the Regional Extension Center.

Mr. Finney stated that CRISP works with all hospital EMRs.

Dr. Winn asked if a physician is not credentialed in a hospital how can the physician get records and how does the patient give consent. Mr. Finney stated that CRISP can credential the physician and that there is wording built into the privacy statement asking for consent. The patient can opt out at anytime. Mr. Finney stated that CRISP is not exchanging psych records.

Dr. Stern stated that the TCAG has been struggling with how telemedicine can be economically viable to the state and asked if it would be helpful to look at some of the economical justifications that CRISP used in its presumptive financial model and suggested that it could inform us of some strategies and in considering a potential liaison with CRISP that could further leverage direct benefits of telemedicine and thereby leverage the financial aspects of CRISP.

Dr. Reynolds asked if there would be a process to streamline the data that the physician requires. Dr. Pimentel noted there should be a report writer that could assist with standardized reports and customized reports.

Dr. Aldrich suggested adding emergency care element to CRISP.

Mr. Finney stated that demand will be driven by the providers up through the organizations where they work. The hospitals will need to be involved with the integration.

Dr. Bass stated that CRISP is an exchange; it give us access to the data, how it is seen and used is up to the physician.

Agenda items for the next meeting:
University of Maryland School of Law presentation
CareFirst presentation

Next meeting: August 18, 2011 at 2:00pm in room 212 at MIEMSS